The hieratic mode

T D V SWINSCOW

Rigid, angular, remote, those priestly figures stand in rows and columns on the tombs of ancient Egypt in overwhelming profusion. Their gestures are stylised, their demeanour authoritative. Are these the portraits, I sometimes wonder, of the authors whose papers I edit for the press? For the style which flows from many medical and scientific writers is so close to hieratic utterance that it might have originated at Luxor. Nobody expects the language of such papers to be remarkable for its euphony or wholly free of the grammatical slips that can take us all unawares. But the person that the style reflects is certainly a weird and wonderful creature.

Beckoning role

No longer, for instance, does an author "record" a case or his observations; he *documents* them. "This paper documents 20 cases of etc." Likewise authors keep clear of observing, reporting, illustrating, or even finding anything; they always *document* it. For underpinning their work, they imply, is a vast deal of scholarly research ("The neurotropic effect of dimethicone is particularly well documented . . ."). And this paper is not just another "contribution to the literature." Rather, it is a weighty addition to scholarship.

But alongside the role of learned scholar another beckons even more compellingly to writers of scientific papers. To them no pressure is ever merely raised, no concentration increased, no response enhanced, no reflex intensified; all are *elevated*. Serum proteins, pulse rates, ankle jerks, body temperatures—what goes up must be elevated. Here the word "elevate" offers the attraction of implying something reverential, almost spiritual, in the writer's approach to his work. An elevated mood, for instance, is undoubtedly more refined and poetic than a heightened emotion or, still more, a raised blood pressure. So an "elevated" blood protein has probably been detected by the caring and committed scientist mixing his sera for the test in the Holy Grail. A priestly role beckons.

This line of thought—if thought it be—is taken a stage further when authors "terminate" (never "end") their experiments on, say, rats and report that at such and such a stage the animals were *sacrificed*. Here indeed the scholar-priest dons his "Men in white" chasuble and draws upon an ancestry that links him with the Druids, the Aztecs, and the lost city of Atlantis. It is true that today the sacrifice is not made at dawn on the altar at Stonehenge, but to whom or what is he making it? To Science? To Knowledge? To Humanity? Certainly to something that needs a capital letter to distinguish it from such dispiriting deities as curiosity, career, or grants committee. And if any British readers hope to comfort themselves with the thought that "sacrifice" for "kill" is merely American boloney I can assure them they are too late. It is rife on this side of the Atlantic.

The hieratic mode of utterance also appears in an odd prepositional clause that now does duty for the old-fashioned adverb "when." Instead of saying, "When his temperature rose

the patient sweated," authors say, "*In the presence of an elevated temperature the patient sweated.*" It is adaptable to any number of contexts: "In the presence of cardiac failure," "in the presence of schizophrenia," even something so abstract as "in the presence of a positive correlation." Thus the priest performs the sacred ritual, conjures the deity out of the darkness of ignorance, and ushers us into the Presence. No wonder the effect on me of so many papers is not so much a gasp of enlightenment as a numbing sense of humility.

Uncommon utterance

One of the commonest (and why are scientific authors afraid of using common in its comparative and superlative degrees, namely, commoner and commonest: they always write "more common," "most common"?): as I was saying, one of the commonest types of statement to appear in papers is that the author did X and Y resulted. But this is, well, too ordinary an utterance, I suppose. So at the very least our author *demonstrated* that Y resulted. More probably he would say, "*We were able to demonstrate* that . . ." or, if he is in expansive mood, "*We were able in this study to demonstrate* that . . ." (an enormously difficult task achieved). But it is not only people who are able to demonstrate this, that, or the other. Electrocardiograms, Paul-Bunnell tests, microscopical slides, CT scans, questionnaires, thin-layer chromatography—all can "demonstrate" something. In fact anything can demonstrate anything in this lingo: "The test demonstrated that the blood proteins . . ." or even "The *absence* of knee jerks demonstrated that etc." Here again the author is living out his Walter Mitty dream, but now, in addition to being priest and scholar he is also the great teacher. He and his patients, his tests, and his findings all *demonstrate* to the expectant reader that a problem has been solved, ignorance dissipated.

Three variations on "to demonstrate" used in the sense of "to show" or merely "to be" are popular. Firstly, anything can *exhibit* anything. "The joints exhibited considerable swelling," "the blood pressure exhibited moderate elevation." Here the author is still in his role of great teacher holding his master-class. But going back into his priestly role he uses another favourite, *reveal*. A physical examination, an x-ray film, a chemical test—all *reveal* something. And, thirdly, all sorts of things *manifest* other things. The patient, or any of the patient's parts, or tests, or investigations can *manifest* a swelling, an "elevated temperature," a "mixed pathology," and much else. With all this revelation and manifestation we are indeed being permitted to peer over the edge of the unknown.

However, patients so called nowadays appear less often in the "literature" than they used to do. This is because they have become *subjects*. "The trial included 20 duodenal ulcer subjects and 10 Crohn's disease subjects, with 20 normals for control." Such are the depths to which a great language is often dragged. And, perhaps not surprisingly, a "subject" rarely suffers from a disease. He has a *condition* or an *entity* or a *manifestation* or even a *phenomenon* (Raynaud's phenomenon has now pushed out disease). With his "subjects" the physician (or surgeon—they do it too) wants to show that he is not merely a doctor engaged in the humdrum task of healing the sick like old Dr Cameron out in the sticks. No, he is a scientist applying systematic observation or experiment to man, rat, baboon—you name it, he's "researching" it. And "subjects" sound more valid than "people" when the time comes for a statistical analysis of the findings.

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A fair maid plundered

And when at last we do come to that fair maid statistics we observe with sorrow that she has been plundered and pillaged to provide a terminology that varies from the pretentious to the erroneous—or, in the case of *parameter*, both. No observation can now be recorded without saying that it is *significant*. “His liver was significantly enlarged,” “the hand was significantly swollen,” the “tongue was significantly red,” and so on ad infinitum. An author (and I speak for myself) is indeed often haunted by the question, Does this work really add up to anything? Surely it must have some significance in the judgment of posterity, or in the opinion of his colleagues, or finally in his own conscience. All right; let there be no misunderstanding then. Everything observed, described, reported, compared must be significant. After all, the thing looks more different than mere chance would allow.

Another term borrowed from statistics, where like “significant” it has a more restricted sense than in common usage, is *population*. No longer does an author report on a series of patients, or a group of them, or a sample; he reports on a *population* of them or even, as I have seen, a *selected population* of them. It sounds like something big, and authors know that big science is better than small science. It is all-embracing too, so that if an author’s results are derived from a “population” they apply to pretty well everyone, not just his series of “subjects.” And, as there is really nothing much beyond the population, that makes the results definitive as well.

On *parameter* I need not labour the lesson. Except in statistical texts, its proper place, the word is now dead, that is, it is used in so many different senses it has lost all meaning and become that characteristic end product of the hieratic mode, mumbo-jumbo.

During the past couple of years I have noted it doing duty as: an indicator in general of disease, a criterion of the severity of disease, a test for the existence of a lesion, a measure of a drug’s effect, the limits or boundary of a syndrome, and the pathognomonic symptom of a particular disease. Farewell, parameter.

In this hieratic language such homely prepositions as “before” and “after” are too commonplace. They have now given way to *prior to* and *following*. Likewise “by,” “with,” and “from” have been thrown away and an entirely new preposition has been created from the participle *using*, which is generally (in entire disregard of correct grammar) in the state called unattached. Thus we see this prepositional linchpin holding up sentence after sentence—for example, “The patient was studied using immunofluorescence,” “the results using that test were positive,” and “surgery was undertaken using a split-level approach.” This nonsensical abuse of language often results in sentences that are as ambiguous as they are barbarous.

Stop pretending

Why do they write in this hieratic mode? My plea is not that they should write better English, with their grammar logical and their vocabulary precise, though I wish they would. Nor is it that in their clinical practice they should scorn the numinous power to comfort and heal that a good doctor has; I wish there was more of that. What I do ask of them is that they should stop pretending they are administering a sacrament when they are simply addressing their professional colleagues. Such people must be disquieting to meet in the flesh—if indeed they ever are incarnate.

Medspeak made simplifax

JAMES ROBB

Medspeak is here to stay. Its continued use is to be encouraged as a method of communication between doctors, though obfuscation often results when it is used with patients. Until recently, Medspeak was a lingua franca, at least among doctors in the English-speaking world. Diversification, however, has inevitably occurred, so that British and American Medspeak are no longer identical. Ideally, a common language such as Mid-Atlantic Medspeak should fuse the two, but until then guidelines are sorely needed for speaker and learner in the interpretation of Medspeak.

On both sides of the Atlantic doctors regularly use prefix and suffix to change word meaning. The frequent use of the prefix *de-* probably began as an easy means of deriving an exact opposite. Now its use is automatic, saving busy doctors the effort of thought to find a better alternative. In this way medical language that was interesting in the past is now being replaced by ersatz Medspeak. Recent examples from the United States include *demystify*, *de-emphasise*, *decolostomise*, and *dephenomenalise*.

The use of the suffixes *-ise* and *-isation* are also a common method of neologising. In America the words *splenectomise*, *colostomise*, and *capsulise* have been used to their best advantage in statements such as “the subject was colostomised” and “the

authors have capsulised the topic.” The economy of American Medspeak is apparent. Perhaps the pedestrian British equivalents are “the patient had a colostomy fashioned” and “the authors have provided a comprehensive review of the topic”—more flowing but less succinct.

Endless possibilities

Another way of creating Medspeak neologisms is to combine the prefix *de-* with the suffix *-ise* or *-isation*. One word can thus burgeon into a whole new range of meanings: noun, verb, and their opposites—for example, *emphasis*, *emphasise*, *de-emphasis*, *de-emphasise*. The possibilities are virtually endless. The advantages of this system to the neophyte neologiser are flexible word-power, economy of thought, and rapid mastery. The disadvantages are turgidity and inelegance. Nevertheless, Medspeak’s continued development is assured because neologising is always fun, and medicine requires an increasingly complex private language to maintain its charisma.

Medspeak, however, can turn fickle as the more advanced Medspeaker faces syntactical niceties such as whether or not to follow common usage. In the United States, for instance, there is an increasing tendency to drop the affix *-al* from the end of adjectives such as *anatomical*, *histological*, *pathological*, which results in such phrases as *the histologic diagnosis*. And in Britain the superfluous use of the affix *-at* still occurs in *preventative* and *dilatation* with surprising regularity.

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